

Colorado Health Plan Description Form
Anthem Blue Cross and Blue Shield
Liberty Plan for the State of Colorado
Effective January 1, 2005 through June 30, 2005

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?¹	Only for emergency care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance options reflect the amount the carrier will pay.

	IN-NETWORK (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4. ANNUAL DEDUCTIBLE	
a) Individual	No deductibles
b) Family	No deductibles
5. OUT-OF-POCKET ANNUAL MAXIMUM²	
a) Individual	\$1,000 (member paid coinsurance) + copayments
b) Family	\$3,000 (member paid coinsurance) aggregate + copayments Eligible charges for Other Mental Health Care and Alcohol and Substance Abuse are included in the out-of-pocket annual maximum.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO Provider Network. See provider directory for complete list.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes
8. ROUTINE MEDICAL OFFICE VISITS	100% after \$50 per office visit copayment
9. PREVENTIVE CARE	
a) Children's services	100% after \$50 per office visit copayment includes immunizations (up to age 13)
b) Adults' services	100% after \$50 per office visit copayment for routine exam
10. MATERNITY	
a) Prenatal care	100% after \$50 per office visit copayment
b) Delivery & inpatient well baby care	\$400 copayment per day for the first five days, then 100% until discharge, per admission

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	IN-NETWORK (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions a) Inpatient care b) Outpatient care c) Prescription Mail Service	<p>Included in hospital copayment (see line 12)</p> <p>Tier 1 generic formulary \$15, tier 2 brand formulary \$40, tier 3 non-formulary \$60, tier 4 self-administered injectable drugs 30%, per prescription up to a 34-day supply.</p> <p>Tier 1 generic formulary \$30, tier 2 brand formulary \$100, tier 3 non-formulary \$150, tier 4 self-administered injectable drugs 30%, per prescription up to a 90-day supply.</p> <p>For the tier 4 self-administered injectable prescription drugs, the 34-day supply maximum coinsurance per prescription is \$250 and \$500 per 90-day supply.</p> <p>Includes coverage for smoking cessation prescription legend drugs when enrolled in an Anthem Blue Cross and Blue Shield approved smoking cessation counseling program, up to \$250 per member per benefit period, \$500 per lifetime.</p> <p>If a provider prescribes a drug for which an FDA-approved Class A generic substitute is available, the benefit will be limited to the cost of the generic substitute. All medically necessary “dispense as written” and “no substitution” prescriptions do not allow a generic substitution and require prior authorization from Anthem Blue Cross and Blue Shield. If a brand name drug is used when a generic equivalent is available, you pay the brand formulary copayment or nonformulary copayment plus the retail cost difference between the brand name drug and generic substitution. For drugs on our approved list, contact Customer Service at 1-800-843-5621 or 303-831-2384. Prescription drugs will be covered only when received from a participating pharmacy.</p>
12. INPATIENT HOSPITAL	\$400 copayment per day for first five days then 100% until discharge, per admission
13. OUTPATIENT/AMBULATORY SURGERY	100% after \$200 per surgery copayment
14. LABORATORY AND X-RAY a) Inpatient care b) Outpatient care	<p>Included with inpatient hospital copayment (see line 12)</p> <p>\$50 per office visit copayment or 20% coinsurance if billed by separate provider of care</p>
15. EMERGENCY CARE³	100% after \$100 per emergency room visit copayment (waived if admitted to hospital) in or out-of-network
16. AMBULANCE a) Ground b) Air	<p>100% after \$200 per trip copayment (maximum benefit of \$350 per trip)</p> <p>100% after \$500 per trip copayment (maximum benefit of \$2,500 per trip)</p>
17. URGENT, NON-ROUTINE, AFTER HOURS CARE a) Inpatient care b) Outpatient care	<p>\$400 copayment per day for first five days then 100% until discharge, per admission</p> <p>100% after \$75 per office visit copayment</p>
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁴	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a) Inpatient care	50% coinsurance per admission (limited to 45 full or 90 partial days per

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b) Outpatient care	benefit period combined with Alcohol Abuse benefits (line 20)) 50% coinsurance per visit (limited to 30 visits with no less than \$1,000 in benefits per benefit period)
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient Care b) Outpatient care	Alcohol abuse: 50% coinsurance per admission (limited to 45 days per year or 90 partial days per benefit period combined with Mental Health benefits (line 19)) Substance abuse: 50% coinsurance per admission (limited to 30 days per benefit period or 60 days per lifetime) 50% coinsurance per visit (limited to 20 visits with no less than \$500 in benefits per benefit period for alcohol abuse; limited to 15 visits per benefit period for substance abuse)
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient b) Outpatient	Included with inpatient hospital copayment (see line 12) 100% after \$50 per office visit copayment (limited to 20 visits each for physical, occupational, and speech therapy)
22. DURABLE MEDICAL EQUIPMENT a) Inpatient care b) Outpatient care	Included with inpatient hospital copayment (see line 12) 20% coinsurance (limited to a maximum payment of \$3,000 per benefit period, combined with oxygen (line 23), except for prosthetic devices which are not subject to the maximum payment but do reduce the maximum payment of \$3,000.
23. OXYGEN a) Inpatient care b) Outpatient care	Included with inpatient hospital copayment (see line 12) 20% coinsurance (limited to a maximum payment of \$3,000 per benefit period, combined with durable medical equipment (line 22))
24. ORGAN TRANSPLANTS	\$400 copayment per day for first five days then 100% until discharge, per admission
25. HOME HEALTH CARE	100% after \$50 per visit copayment (limited to 60 visits per benefit period)
26. HOSPICE CARE a) Inpatient Care b) Outpatient care	20% coinsurance (limited to 30 days per benefit period) 20% coinsurance (limited to 91 days per benefit period)
27. SKILLED NURSING FACILITY CARE	Not covered
28. DENTAL CARE	No dental benefits are available under this medical plan. However, the State of Colorado offers a separate dental plan for eligible employees and dependents. See enrollment materials.
29. VISION CARE	Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description.
30. CHIROPRACTIC CARE	100% after \$50 per visit copayment (limited to annual payment of \$300)
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline. When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions. A benefit period begins on the subscriber's effective date, and expires on the following June 30.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ⁵	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan, sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	USING THE PLAN
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
39. What is the main customer service number?	303-831-2384 or 1-800-843-5621
40. Whom do I write/call if I have a complaint or want to file a grievance? ⁶	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2384 or 1-800-843-5621
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form # 98467 Large Group

PART E: COST

43. What is the cost of this plan?	Employee Portion	State Contribution	Full Premium
Employee Only	\$168.30	\$178.06	\$346.36
Employee + 1 Dependent	\$385.88	\$303.50	\$689.38
Employee + 2/More Dependents	\$543.78	\$420.02	\$963.80

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT

Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan, may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?

What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Endnotes:

¹ "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

² "Out-of-pocket maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

³ "Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or limb threatening emergency existed.

⁴ "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

⁵ Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

⁶ Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

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